



751 Hebron Pkwy Ste 310  
Lewisville, Texas 75057  
469-549-4200

## **CONSENT AND CONFIDENTIALITY**

I understand that the information provided and exchanged regarding myself (or my child in the case of a minor) and this case involves confidential information. The information disclosed in this evaluation is considered *confidential* and thus subject to the state and federal rules governing confidentiality of psychological information including but not limited to: The Americans with Disabilities Act and the Health Insurance Portability and Accountability Act of 1996 or HIPAA, Section 164,508.

I understand that any and all information disclosed in the course of the interview(s), including any findings from any psychological or neuropsychological testing, will be provided to the TWC as part of this assessment process. Any and all information in the form of verbal and written reports of findings will be the property of TWC and any and all professional opinions will be made directly to TWC.

I agree to voluntary participation in this evaluation, and I understand the limits to confidentiality. I have been asked to offer my fully informed consent to participate voluntarily and without coercion in the evaluation as explained and understood under the specific conditions of this evaluation.

I understand that my participation in this evaluation does not in any way constitute treatment by Johnson Neuropsychology, PLLC nor does this participation constitute any type of therapeutic relationship or contract of a therapeutic relationship and only represents a psychological or neuropsychological evaluation and a report of findings and professional opinion to TWC.

I agree, within the bounds of reasonable insight and a sense of personal awareness, to the best of my present capacities and abilities, to disclose the truth during this evaluation process, whether on interview and/or psychological testing.

I understand that my signature on this document represents an acceptance of the stipulation that the test results will be reported in the written report of psychological or neuropsychological evaluation to the referral source and that the test information and materials (or “raw data” or “work product”) will remain the exclusive, confidential property of Johnson Neuropsychology, PLLC.



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I understand that the “work product” of the evaluation will not be available for release to the TWC, or to myself, as only the results, interpretations and professional opinions developed from these materials will be reported to TWC and will become the exclusive property of Johnson Neuropsychology, PLLC and the responsibility of TWC to protect the confidentiality of the document and to only release the psychological or neuropsychological evaluation according to the rules and regulations governing such confidential information.

I agree that I am deemed clinically competent to make this informed consent and understand the limits of confidentiality as a necessary requirement for my participation in this evaluation. I am freely signing this statement as a competent and reasonable person capable of making a fully informed consent to participate and to waive confidentiality under the specific provisions of this evaluation as explained, understood and accepted and am completely willing to proceed with the evaluation under these explicit conditions.

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_  
(or parent signature if patient is a minor)

Date: \_\_\_\_\_